

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3564SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2009
NAME OF PROVIDER OR SUPPLIER CAREMERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 7690 CARMEN BLVD LAS VEGAS, NV 89128		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 000	<p>Initial Comments</p> <p>Surveyor: 26251 This Statement of Deficiencies was generated as a result of a complaint investigation conducted at your facility on November 19, 2009 in accordance with Nevada Administrative Code, Chapter 449, Facilities for Skilled Nursing.</p> <p>Three complaints were investigated.</p> <p>Complaint #NV00022528 was substantiated with deficiencies. (See Tags Z64, Z240, Z241, Z271, and Z310)</p> <p>Complaint #NV00022980 was unsubstantiated.</p> <p>Complaint #NV00023306 was unsubstantiated.</p> <p>A Plan of Correction (POC) must be submitted. The POC must relate to the care of all patients and prevent such occurrences in the future. The intended completion dates and the mechanism(s) established to assure ongoing compliance must be included.</p> <p>Monitoring visits may be imposed to ensure on-going compliance with regulatory requirements.</p> <p>The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws.</p> <p>The following regulatory deficiencies were identified:</p>	Z 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3564SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2009
NAME OF PROVIDER OR SUPPLIER CAREMERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 7690 CARMEN BLVD LAS VEGAS, NV 89128		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z 64	Continued From page 1	Z 64		
Z 64 SS=D	NAC 449.74429 Transfer or Discharge of Patient 5. A facility for skilled nursing shall prepare a patient for his transfer or discharge in such a manner as to ensure the safe and orderly transfer or discharge of the patient from the facility. This Regulation is not met as evidenced by: Surveyor: 26251 Based on interview and record review, the facility failed to ensure facility nursing staff provided a patient transfer and referral record and specific medication administration information regarding Provigil to emergency personnel for 1 of 6 residents (Resident #1). Severity: 2 Scope: 1	Z 64		
Z240 SS=D	NAC 449.74471 Administration of drugs 1. A facility for skilled nursing shall not administer a drug to a patient in the facility: (a) In excessive doses, including duplicate drug therapy; (b) For an excessive duration; (c) Without monitoring the patient properly; (d) Without adequate indications for the use of the drug; or (e) If there are any adverse reactions which indicate that the dosage should be reduces or discontinued. This Regulation is not met as evidenced by: Surveyor: 26251 Based on interview and record review, the facility failed to provide adequate indications for the use of the drug Provigil for 1 of 6 residents (Resident #1). Severity: 2 Scope: 1	Z240		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3564SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2009
NAME OF PROVIDER OR SUPPLIER CAREMERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 7690 CARMEN BLVD LAS VEGAS, NV 89128		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z241	Continued From page 2	Z241		
Z241 SS=D	<p>NAC 449.74471 Administration of Drugs</p> <p>2. Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that a patient who:</p> <p>(a) Has not used an antipsychotic drug is not given such a drug unless it is required to treat a condition of the patient that has been diagnosed and documented in the medical record of the patient.</p> <p>(b) Use an antipsychotic drug receives gradual reductions in the dosage, in conjunction with behavioral intervention, in an attempt to discontinue the use of the drug, unless the medical condition of the patient requires otherwise.</p> <p>This Regulation is not met as evidenced by: Surveyor: 26251 Based on interview and record review, the facility failed to provide a diagnosis, physician progress note, or other specific treatment documentation for the use of the drug Provigil for 1 of 6 residents (Resident #1).</p> <p>Severity: 2 Scope: 1</p>	Z241		
Z271 SS=D	<p>NAC 449.74479 Urinary Problems</p> <p>Based on the comprehensive assessment of a patient conducted pursuant to NAC 449.74433, a facility for skilled nursing shall ensure that a patient:</p> <p>2. Who is incontinent receives the services and treatment needed to prevent the infection of his urinary tract and restore the normal function of his bladder.</p> <p>This Regulation is not met as evidenced by: Surveyor: 26251 Based on interview and record review, the</p>	Z271		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3564SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/19/2009
NAME OF PROVIDER OR SUPPLIER CAREMERIDIAN		STREET ADDRESS, CITY, STATE, ZIP CODE 7690 CARMEN BLVD LAS VEGAS, NV 89128		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Z271	Continued From page 3 facility's nurses failed to document and provide Foley catheter care according to facility policy for an eleven day period resulting in a urinary tract infection for 1 of 6 residents (Resident #1). Severity: 2 Scope: 1	Z271		
Z310 SS=D	NAC449.74493 Notification of Changes or Condition 1. A facility for skilled nursing shall immediately notify a patient, the patient's legal representative or an interested member of the patient's family, if known, and, if appropriate, the patient's physician, when: (a) The patient has been injured in an accident and may require treatment from a physician; (b) The patient's physical, mental or psychosocial health has deteriorated and resulted in medical complications or is threatening the patient's life; (c) There is a need to discontinue the current treatment of the patient because of adverse consequences caused by that treatment or to commence a new type of treatment; (d) The patient will be transferred or discharged from the facility; (e) The patient will be assigned to another room or assigned a new roommate; or (f) There is any change in federal or state law that affects the rights of the patient. This Regulation is not met as evidenced by: Surveyor: 26251 Based on interview and record review, the facility failed to ensure nursing staff notified the physician of family refusal regarding an ordered medication (Provigil). Consequently the physician never discontinued the medication or ordered an alternative treatment for 1 of 6 residents (Resident #1).	Z310		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NVS3564SNF	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/19/2009
NAME OF PROVIDER OR SUPPLIER CAREMERIDIAN			STREET ADDRESS, CITY, STATE, ZIP CODE 7690 CARMEN BLVD LAS VEGAS, NV 89128		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
Z310	Continued From page 4 Severity: 2 Scope: 1	Z310			

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.